

HELPING THE DEAF-BLIND
TO FACE THE FUTURE
Edward J. Waterhouse

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Helping the Deaf-Blind to Face the Future

EDWARD J. WATERHOUSE,

Director
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REHABILITATION WORKERS are rightly concerned more with handicapped adults than with children. It is hoped that this article, while admittedly written from the viewpoint of the school, may throw some light on the problems of deaf-blind adults as well as those of children.

Perkins School for the Blind has had a special department for deaf-blind children for over twenty-six years. Ever since Laura Bridgman was admitted in 1837, there have been a few such children in the School; this year there are twenty-four in the department, the largest number the School has ever had. It is probably the largest number of deaf-blind children ever enrolled in any school, either in the United States or elsewhere.

Sometimes it seems as though the problems of these children, who make up just nine percent of the total School enrollment, are greater than the combined problems of the remaining ninety-one percent.

There can be few complications more baffling than the combination of deafness with blindness. Deaf people who can see find that they can substitute sight for hearing in many effective ways—lipreading, for example, and observation of facial expressions. Blind people who can hear pay unusually effective attention to the sounds around them, and many use effectively in travel the so-called "facial vision" which seems to be entirely dependent on hearing. By means like these a goodly number of the deaf and the blind live amazingly normal lives.

When both sight and hearing are impaired, so that substitutions of one for the other are impossible, both handicaps are rendered more profound. The sense of touch, which is the most valuable one remaining, can often with intensive training become an adequate channel of communication but is clearly of too short a range to help very much in travel. Thus the two greatest handicaps resulting separately from deafness and blindness—namely, communication and travel—are increasing in intensity.

Who Are the Deaf-Blind?

Deaf-blind persons form a relatively small group, but the diversity of handicaps found within it is very great—far greater than is normally found within a group of deaf or blind persons. Workers with handicapped people recognize that the age when a sensory loss occurs is always



Learning Braille is no easy task even for one who has both hearing and vision, but this boy who has neither is doing his best.

an important factor and frequently the dominating one in determining a client's needs. With the deaf-blind, special significance attaches to the age at which each of the two losses occurs. In most cases the impact of the second loss, if it happens after infancy, is very great indeed. Clearly the variables commonly encountered among handicapped persons are multiplied severalfold. Nor must it be forgotten that deaf-blind persons are at least as susceptible as others—perhaps more so than the public at large—to still further handicaps, such as cerebral palsy, mental retardation, and cardiac conditions.

Since the degree of either loss can vary greatly, the word "deaf-blind" can have almost limitless shadings of meaning. Persons completely without sight or hearing are relatively few. On the other hand, a person with a slight visual impairment which would not normally call for rehabilitation services, may need considerable assistance if he is also deaf. The same can apply to the blind person with a slight hearing loss. It is the combination of handicaps which brings about the need for special educational or rehabilitational programs.

In this connection it is significant that the National Study Committee on Education of Deaf-Blind Children defines a deaf-blind child as "one whose combination of handicaps prevents him from profiting satisfactorily from educational programs provided for the blind child or the deaf child." This definition has been accepted by the Conference of Executives of American Schools for the Deaf and the American Association of Instructors of the Blind.¹

Primarily Blind or Primarily Deaf?

According to the degree of handicap, it is possible to accept a number of deaf-blind persons into programs intended for the blind or for the deaf. If one handicap is severe and the other one not too intense, this can be satisfactory. If the handicaps are about equal, the deaf-blind person may actually find himself "falling between two stools" while (to confuse the metaphor) two agencies with perhaps the sincerest intentions of reaching the best solution to their client's problem, put on an Alphonse and Gaston act. For example, we often find a school for the deaf and a school for the blind each convinced that the other is able to provide a better program for a deaf-blind child

Social progress makes the well-being of all more and more the business of each.

—HENRY GEORGE

2. *Protection* of employees against conditions actually or potentially harmful. The occupational medicine specialist is concerned with the health hazards arising from dusts, industrial poisons, solvents, radiation, etc. He is equally anxious over threats to mental health inherent in the stresses and pressures of modern industry. The research and activities of occupational medicine in the field of mental health will increase understanding and lead to more careful evaluations of the working potential of employees and job applicants who have emotional and mental problems. Thus, in just this one area, upon which so much rehabilitation attention is presently centered, the specialist complements and supplements the work of the counselor.

3. *Medical examinations*, preplacement and periodic, for employees. The purpose of the preplacement examination is to determine the medical fitness of the examinee to work without danger to himself and others. The use of the term "preplacement examination" in lieu of "pre-employment examination" is meaningful. To illustrate: A statement on a pre-employment examination report might read, "This applicant is a cardiac. He should not be employed." A preplacement examination summary might advise, "This man has a mild cardiac condition. He is medically acceptable for work as a bookkeeper in the shipping department." In this way, occupational medicine promotes employment of the handicapped and opens new job opportunities for rehabilitation clients.

Periodic examinations are made to discover disease and to diagnose illness among employees as well as to assure safe return to work after extended periods of absence for health reasons. The occupational health specialist realizes that health is not static. He knows that the employee who is symptom-free today may have—or exhibit definite signs of—serious illness six months from now. For that reason, in most plants which have facilities and personnel practicing occupational medicine, employees are examined periodically. The results of a study made in one such plant demonstrate the value of these examinations: Fifty percent of 500 executives, all under forty years of age, were found to have unsuspected physical ailments.

The periodic and preplacement examinations identify persons vocationally handicapped by disability. By making his interest in and services for these people known to the in-plant health department personnel, the counselor can tap new sources for case-finding.

4. *Employee counseling services* on health and other matters, including referral of workers to their private physicians for necessary care of non-occupational conditions, education on nutrition, instruction in first-aid procedures. The need for employee counseling is pointed up by the case of a worker sent to the health unit because of inattention to his job. Upon inquiry it was learned that he had just been notified that the public school system would not enroll his mentally handicapped daughter as a student; his wife had threatened to leave him; he had been involved in an auto accident and was responsible for uninsured damages; and his debts exceeded \$3,500. Is it any wonder that he was preoccupied?

Special Problems, Mutual Benefits

Alcoholism presents serious problems to industry and services are being developed to help addicted workers. An allied concern of the occupational medicine specialist is

the human relations factor in industry. The importance of this factor is underscored by the fact that sixty to eighty percent of industrial dismissals are due to social incompetence. One survey revealed that over sixty percent of workers absent only once in six months were satisfied with the degree of job responsibility assigned to them, whereas only thirty-five percent were satisfied with their assigned responsibility.

The highlights of occupational medicine interests common to those of rehabilitation have been sketched here. The counselor is charged with the *total rehabilitation* of his client; the specialist has the *total well-being* of his worker-patients as his responsibility. Particularly where and when occupational disability which is vocationally handicapping occurs, the goals of the two disciplines are identical; the services of each can and should be integrated for continuity and maximum effect.

In other areas, too, liaison and a working-together between the counselor and the specialist will be of mutual benefit. This relationship, however, must be established. As the doctors—the general practitioners, the industrial physicians, and the specialists—become even better trained in the many aspects of occupational medicine they will know more about selective placement factors—e.g., working conditions and environment, job demands and job analysis; more about individual needs and differences among workers; more about habilitation and rehabilitation concepts. Through them and their contacts with personnel and other officials of management, the counselor can anticipate and develop closer cooperation in finding suitable job assignments for workers handicapped by occupational and non-occupational disability.

Insurance Cost Factor

One observation on the negative side: Among the larger industries (9 out of 10 organizations hiring 5,000 or more employees already have in-plant health services) management increasingly is assuming all or part of the cost of providing employees with insurance for hospitalization, medical, and surgical services, as well as protection against loss of income because of non-occupational disability. Initially, a uniform premium rate was charged by the carriers; now, as in other forms of insurance, premium rates are based upon cost experiences and the charges vary from plant to plant. There is a definite awareness of the "disability risk" factor or the economic liability involved in hiring a new employee with any condition which might lead to a later claim for benefits. In commenting upon this one industrial leader frankly acknowledged, "Unless the job applicant who is disabled has a particular skill we desperately need, we will not employ him. We cannot afford to take the risk." If small industries follow this lead of underwriting costs of non-occupational disability insurance for employees and adopt similar thinking, it will be increasingly difficult for the handicapped person who has had no work experience or who is re-entering the labor market to find a job with a new employer. Counselors should take cognizance of this trend in their client counseling.

Summary

The specialty of occupational medicine, as it is currently defined, is relatively new. The objective is the promotion and conservation of the health of workers *for* the job, not just *on* it. Non-occupational disability will be treated as importantly as occupational disability. Training in occupational medicine will be specialized. The counselors must know of this discipline and prepare to work with its member physicians.

referred to them both for placement. No doubt a similar situation sometimes exists where adults are concerned.

When both handicaps are profound, the problem can indeed be baffling. Such understanding as we have of the psychology of blind or deaf people is then of little use, for the handicap of deafness-blindness, as suggested earlier in these observations, is something more than the sum of its component losses—and something very different. It is a distinct handicap apart from any other and needs to be treated as such.

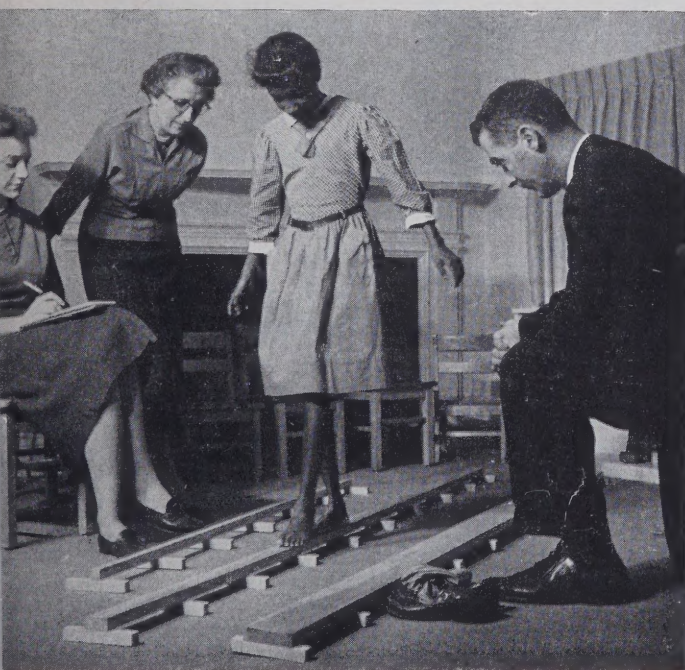
The Dimensions of the Problem

Fortunately, the number of deaf-blind persons is relatively small. This good fortune is for the many who have been spared the loss of these two senses, for the very smallness of the group intensifies the problems of those within it. If there were as many deaf-blind persons as there are deaf or blind or crippled, then programs, both of services and of research, comparable to those that exist for these larger groups would no doubt have long since been established for the deaf-blind also. When numbers are below a certain level in a community, organized programs of services are scarcely feasible.

Rehabilitation programs for the deaf-blind in the United States are very few indeed, the outstanding example being those conducted by the Industrial Home for the Blind, located in Brooklyn, New York, in the largest center of population to be found anywhere. The American Foundation for the Blind also offers valuable services to the deaf-blind, mainly of a consultative nature, from its headquarters in New York.

The small numbers involved are clearly revealed among the deaf-blind of school age. Surveys conducted by the American Foundation for the Blind indicate that there are approximately two hundred children with this double handicap in the United States, less than half of whom are enrolled in special programs. It is not wise to make too many deductions based on these statistics. Some of these children now deprived of a suitable education, or indeed

Special methods and equipment have been devised for training the deaf-blind in the basic skills required for the activities of normal day-to-day living. Here a group of future teachers observe a child's progress in overcoming the difficulties imposed by her dual handicap.



Let no one think that children who can neither hear nor see are without capacity for enjoyment. These four are having a really good time with the game they are playing.

any education, may not be educable. The incidence of mental retardation among the deaf-blind has never been scientifically determined, but it undoubtedly is high.

On the other hand, widespread ignorance of the educational potential of deaf-blind children, as well as of the available educational services, may have kept names off the Foundation's list which rightly belong there. It is a regrettable fact that a considerable proportion of the deaf-blind children who at one time or another have entered the Perkins Deaf-Blind Department and proved to be educable had been diagnosed in infancy as imbeciles. The figure of two hundred may be too small, but it seems unreasonable to suppose that this is less than half the true figure. Probably there are far fewer than four hundred in this country.

Compare this rough guess with the figure of ten thousand or more legally-blind school-age children registered with the American Printing House in Louisville, Kentucky, and the more than twenty-seven thousand deaf children reported in the 1956 Year Book of the Encyclopedia Britannica. The uncertain statistics of deaf-blind children then fall into clearer perspective. Projecting this school-age comparison into adulthood, after allowing for copious errors, it seems clear that the number of deaf-blind adults is small. However, just about all of them require rehabilitation services, and these services are complex and make unusual demands on both the time and the skills of rehabilitation workers.

Beginnings in Research

It is not surprising that little research has yet been done with the deaf-blind. School groups which have provided many opportunities for the study of handicapped children are too small for such purposes. Among the 24 students now enrolled at Perkins it would be hard to find two who are alike in age, degree of handicap, and educational experience. Nevertheless, some research has been attempted and prospects for more are better than in the past.

Diagnosis and Evaluation

Useful research has already been carried out by Dr. Helmer R. Myklebust in the Speech Clinic at Northwestern University and at Perkins School, and a report of this project is available.² Since psychological tests based on massed studies are clearly impractical, this study provides an alternative approach to the evaluation of deaf-blind children.

(Continued on page 15)

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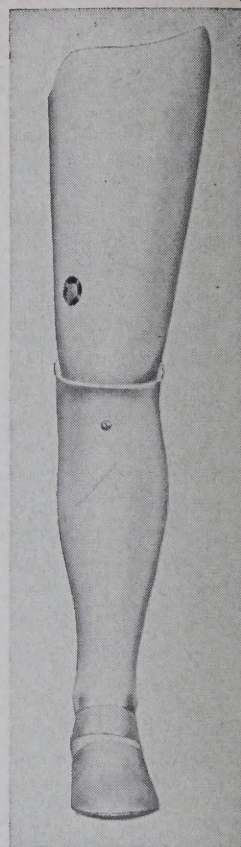
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Helping the Deaf-Blind

(Continued from page 7)

Another stumbling-block to research has been the lack of trained persons to direct it and competent workers to carry it out. The establishment in 1956 of a joint training course for teachers of deaf-blind children by Boston University School of Education and Perkins School for the Blind brought together for the first time a group of young men and women competent to participate in research projects on the thesis level. The influx of new teachers has also made it possible for Mr. Daniel J. Burns, who heads the Perkins department for deaf-blind children, to release one of his most experienced and competent teachers, Mrs. Gertrude L. Stenquist, for research purposes. Nevertheless, with the small group of children and the wide variations noted, much of the research will continue to be in the nature of case studies.

The Future of Deaf-Blind Children

Each year between ten and twenty deaf-blind children reach the age of twenty, which for most of them represents the end of their school careers. What their future will be depends, in part, on what rehabilitation services are available to them.

As educators look forward with hope to their pupils' futures, rehabilitation workers ask what kind of material they may expect to welcome as clients. Perhaps then it will be helpful to cite a few illustrations of what can be accomplished when natural abilities are released and developed by training. The examples given below are taken, except where otherwise noted, from files of girls and boys who have been students at Perkins.

Workers may expect to encounter a wide variety of skills and personalities, corresponding to the diversity of handicaps. There will be few—a very small number—who are of college caliber, almost certainly persons who lost one of their two senses after their schooling was well under way. To the best of our knowledge, only one person who became totally deaf and blind in infancy has ever acquired a college degree. That, of course, was Helen Keller, and rehabilitation workers are not likely to meet anyone like

her in our generation. She is, of course, the supreme inspiration of workers with the deaf-blind, and the distant star towards whom parents of all deaf-blind children turn.

Typical of a slightly larger group among the deaf-blind is Robert Smithdas, who graduated with honors from Perkins in 1945 and subsequently obtained a bachelor's degree, *cum laude*, from St. John's College in Brooklyn, New York, and his master's degree from New York University. Robert had sight until he was four and hearing until he was eleven. All the same, this is an outstanding accomplishment and there are only a few deaf-blind persons in this country who can match it. Today Robert occupies a professional position on the staff of the Industrial Home for the Blind in Brooklyn.

Among others who were deprived of their two senses at a comparatively late age and proceeded to college is Richard Kinney, instructor at the Hadley Correspondence School for the Blind, in Evanston, Illinois. (Richard Kinney was never a Perkins pupil.)

A larger group are found employed in factories. These include Edward Reis, who is employed as a machine operator in the same factory as his father in New Jersey. Leonard Dowdy has held several positions in industry in his native state of Missouri. Both of these boys received additional training after leaving Perkins, at the Industrial Home for the Blind.

There are some eminently successful deaf-blind housewives, notably Helen Hayes Shultz of Minnesota, who also at one time participated actively in the activities on her husband's farm.³

The importance of family to deaf-blind persons cannot be overestimated. One particularly fortunate person in this regard is Juanita Morgan of Colorado, who lost both sight and hearing in infancy. Juanita acquired excellent speech during the thirteen years she was at Perkins and is able to lipread strangers with her fingers, to speak to them clearly and pleasantly. Since leaving this school she has lived at home, where she occupies herself very happily both with housework and with handicrafts from which she is able to earn a useful amount annually.

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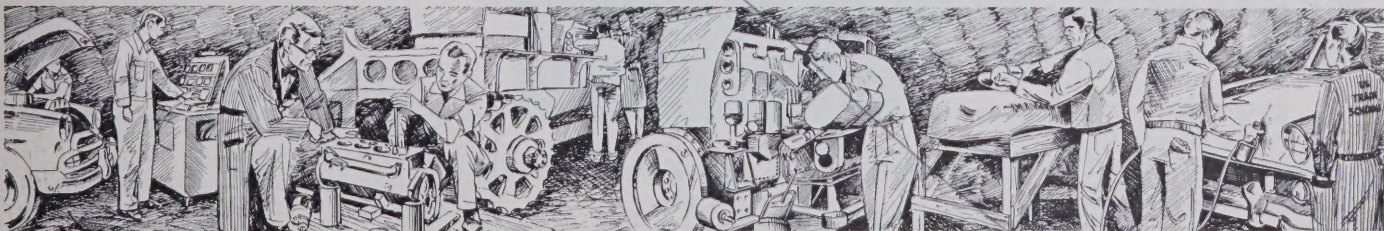
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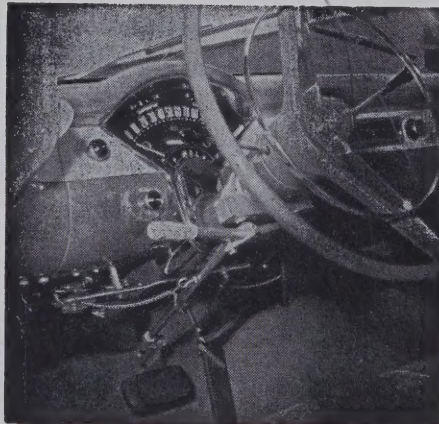
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Further down the line are those who
have required a custodial program.

Clearly, no two of these deaf-blind
people made the same demands upon
rehabilitation services. The competent
rehabilitation worker, with experience
in diagnosing a client's needs and re-
cognizing that with deaf-blind persons,
even more than with other groups of
the handicapped, the needs are diverse,
should be able to plan a useful pro-
gram for a deaf-blind client. The
problem of communication may be
serious, but there are many methods in
use which are well described in a pam-
phlet published by the American Founda-
tion for the Blind.³

In addition, the problem of travel
is likely to be more severe than for
other clients. There are, however, a
few deaf-blind people traveling alone
in city traffic from their homes to the
workshops of the Industrial Home for
the Blind in Brooklyn, New York; so
it should not be assumed that inde-
pendent travel is always an impossi-
bility.

Need for the Human Touch

Perhaps the key to services for the
deaf-blind is found in Helen Keller's
description of them as "the loneliest
people on earth." A program which
does not allow for social contacts and
for recreational experiences is not like-
ly to produce a happy client. Wherever
possible in a workshop, another worker
should be fairly close to the deaf-blind
person, and fellow workers and fore-
men should be encouraged to make
frequent, even though fleeting, con-
tact with him. This may not need to
be more than a hand on the shoulder
in passing. Somehow the void of deaf-
ness-blindness needs to be filled up.

Frequently the greatest need for the
deaf-blind person is to have someone
to converse with so he may feel that
he maintains his place, not only as an
individual, but as a member of society.
Hence the need for carefully planned
recreation. A number of our children
are keen competitors in games, such
as checkers and cards, and some of
them are avid baseball fans. They
carry these interests into adult life.
Some of our students have been good
wrestlers in school, and Eddie Reis
won the championship in his weight
class among blind wrestlers in the
Eastern United States—an accomplish-
ment which possibly may have greater

significance to him than anything else he can accomplish.

Probably few deaf-blind persons will become wholly independent; consequently, their well-being depends on the understanding cooperation of agencies and individuals.

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THE DEAF-BLIND face formidable problems; but they do not face them alone. The World Council for the Blind is working in their behalf through its Committee on Services for the Deaf-Blind, which met last summer under the chairmanship of Peter J. Salmon, who heads the Industrial Home for the Blind in Brooklyn, New York. Its two weeks of concentrated study, in Chicago and at IHB headquarters, proved richly productive. Recommendations included: (1) the establishment of two standard manual alphabets—one for the layman, the other for intimates and co-workers—doing away with present diversity; (2) research into skin sensitivity factors, to determine the best positioning for manual conversation.

It is good to know that this world conference had the support of the American government, not only through the Office of Vocational Rehabilitation which helped to make its meetings possible but through encouragement from President Eisenhower, who welcomed the group to the White House and displayed eager interest not only in the problems of the deaf-blind in general but in the individuals present and the various methods, manual and machine, which they used in communicating with one another.



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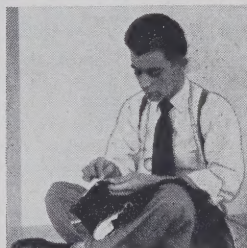
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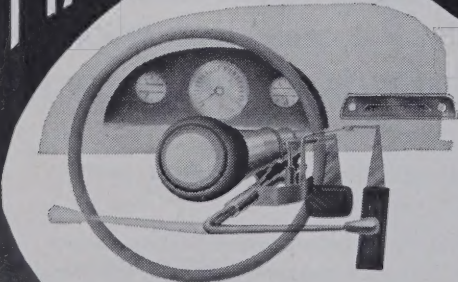
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World Congress

(Continued from page 11)

Among the distinguished rehabilitation figures from the United States who took an active part in the broad Congress program were: Mildred Elson, vice-president, World Confederation for Physical Therapy; Willis C. Gorthy, director, Institute for the Crippled and Disabled, New York; Dr. Henry H. Kessler, director, Kessler Institute for Rehabilitation; Maj. Gen. Melvin J. Maas, chairman, The President's Committee on Employment of the Physically Handicapped; Dr. Eugene F. Murphy, chief of prosthetic research, Veterans Administration; Dr. Dean W. Roberts, executive director, National Society for Crippled Children and Adults; Mary E. Switzer, director, U.S. Office of Vocational Rehabilitation; Eugene J. Taylor, The New York Times; P. J. Trevethan, executive vice president, Goodwill Industries of America; and the executive director of the National Rehabilitation Association, E. B. Whitten.

Large Exhibition

Over sixty exhibits from all over the globe were assembled in the Central Hall. They represented the largest international attempt to show in graphic form how the disabled can meet their everyday problems—how they are treated, cared for, trained and employed. Many of the methods and appliances on display had never before been given a public showing.

A large number of exhibits from the United States were mounted. The Joseph Bulova School of Watchmaking depicted effectively its functions, facilities, and results. The United States Prosthetic Research Board showed the organization of its artificial limb program, with examples of the results achieved. The National Foundation for Infantile Paralysis pointed up the "team" approach to program planning in all phases of patient care, convalescence, and final rehabilitation. And there were numerous other American organizations represented, conveying an impressive picture of the wide spread work being done in this country to equip the disabled to take a normal place in society. In memory of Bell Greve, Dr. Howard A. Rusk, on behalf of the World Rehabilitation Fund, presented a special cash award to the especially effective exhibit set up by Denmark.

Lasker Awards

The Congress was also the occasion for the presentation of three world renowned Albert Lasker Awards for outstanding individual or group

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